Patient Information

Please present health insurance card and co-payment to front desk when applicable. Thank-you.

PATIENT Information: (**PLEASE PRINT**) Today's Date: _____/_____/_____

First Name M.I. Last

Address City State Zip

Home # ( ) Work # ( ) Cell # ( )

E-Mail Language Ethnicity

Soc. Sec. # Birth Date Gender: ☐ Female ☐ Male

Employment Status Occupation

Employer/School Name Address

Marital Status: ☐ Single ☐ Married, Spouse's Name _____ ☐ Other _____ (PLEASE SPECIFY)

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____ (PLEASE SPECIFY)

Preferred Contact: ☐ Home # ☐ Cell/Mobile # ☐ Work # ☐ E-Mail ☐ Other _____ (PLEASE SPECIFY)

YOUR Pharmacy:

(NAME OF PHARMACY) (ADDRESS) (PHONE)

Incase of an EMERGENCY notify?

Full Name Phone ( ) Relation

REFERRED BY? ☐ Our Patient _____ (NAME) ☐ Friend/relative _____ (NAME) ☐ Self/other _____

How did you hear about us? ☐ Our Website ☐ Phone Book ☐ Facebook ☐ Attorney ☐ Staff Member _____ (NAME)

☐ Physician's Office ☐ SuperPages.com ☐ Consumer Guide to Plastic Surgery ☐ Health Insurance ☐ Radio ☐ ASPS Website

☐ Google ☐ Yahoo ☐ Newspaper Ad ☐ Lowell General Hospital ☐ Allergan/Find a Doctor ☐ Other Advertising_____ (EXPLAIN)

PARENT / GUARDIAN Information - Must be completed if patient is under 18 years old.

First Name M.I. Last

Address City State Zip

Home Phone ( ) Work Phone ( ) Relation to Patient

PRIMARY INSURANCE NAME: Relation to Patient ☐ self ☐ parent ☐ spouse ☐ other

Insured's Full Name Birth Date Gender ☐ Female ☐ Male

Policy/ID No. Employer Name/Address

SECONDARY INSURANCE NAME: Relation to Patient ☐ self ☐ parent ☐ spouse ☐ other

Insured's Full Name Birth Date Gender ☐ Female ☐ Male

Policy/ID No. Employer Name/Address

Continue to back page…

Dina Eliopoulos, MD
Center for Plastic Surgery
9 North Road, Suite 202, Chelmsford, MA 01824

Practice Policies/Consents

PRIVACY POLICY ACKNOWLEDGEMENT

My signature below acknowledges that I have been made aware of Dina Eliopoulos, MD privacy policies as mandated by HIPAA. I have been given the opportunity to read and ask questions regarding Dina Eliopoulos, MD's privacy policies. A copy of this policy has been mailed to me or given to me upon my first visit. This acknowledgement will remain a permanent part of my medical record. **I acknowledge having received a copy of Dr. Dina Eliopoulos' Notice of Privacy Practices**.

_____ _____ _____
Patient /Parent/Guardian Signature Patient Name **(PLEASE PRINT)** Date

ASSIGNMENT OF INTEREST

I authorize direct insurance benefit payment to Dina Eliopoulos, MD for any medical expense incurred by me and/or any covered dependent. This assignment will remain in effect until revoked by me in writing. I also authorize release of any medical information, including photos required to process insurance claims and/or prior authorization for surgery. I further understand that I am financially responsible for all balances remaining after insurance benefit determination.

_____ _____
Patient /Parent/Guardian Signature Date

OFFICE BILLING POLICIES

Please take a moment to become familiar with our billing policies. If you have any questions please do not hesitate to ask our office staff, we will be more than happy to assist you (978-275-9440).

- Payment in full is required at the time of service unless other arrangements have been made.
- The person who is receiving our services has the sole financial responsibility for our charges. Exception: Minors (under 18 year of age). The custodial parent/guardian would assume full financial responsibility.
- Dina Eliopoulos, MD will file third party medical claims directly for the patient assuming that complete insurance information and assignments have been provided. Co-pays are due on the date of service. Payment of the entire bill remains the responsibility of the patient or custodial parent/guardian. Payment of any balances remaining after insurance submission also remains the responsibility of the patient or custodial parent/guardian.
- A $25.00 service fee plus any bank fees will be charged due to insufficient funds on all returned checks. In the event of a returned check final payment will be due immediately.
- Collection Agency fees will be applied to any outstanding balances owed.
- Referral policy: It is the patient's or custodial parent/guardian's direct responsibility to provide Dina Eliopoulos, MD with a current/valid referral from his/her primary care physician or his/her health insurance carrier. Referral must be received by the date of service or the patient or custodial parent/guardian will be held financially responsible for the cost of the visit.

_____ _____
Patient /Parent/Guardian Signature Date

CONSENT FOR PHOTOGRAPHS

I understand and approve that any photographs and/or videotapes taken as part of the procedure/surgery will become the property of my physician and or medical records. I also consent to the use of such photographs as evidence in a legal proceeding, or for educational or research purposes or for use of requesting prior authorization for health insurance coverage, or for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. ***By signing here, this does not give us permission to use your pictures for our website, any marketing, or for our before and after books. A separate consent would be requested in the future for these purposes.**

_____ _____
Patient /Parent/Guardian Signature Date

Dina Eliopoulos, MD

Center for Plastic Surgery
9 North Road, Suite 202, Chelmsford, MA 01824
Tel: (978) 275-9440 - Fax: (978) 275-9470

History & Physical

Patient Name: _____ **Birth Date**: _____/_____/_____ **Date**: _____/_____/_____

Reason for this visit: _____

Primary Care Doctor: _____
(Name) (Address) (Phone #)

When was your most recent physical check up? _____
(Date)

Have you ever had the following?

	Yes		Yes		Yes		Yes
Heart disease		Sleep apnea		Urinary tract infection		Eczema	
Cong. heart failure		Tuberculosis		GERD		Hives	
Chest pain/tightness		Liver disease		Intestinal disorder		History of Accutane	
Heart murmur		Hepatitis		Hernia(s)		Keloid / thickened scars	
High blood pressure		AIDS or HIV+		GYN problems		X-Ray Therapy/ Radiation	
Pacemaker		Abnormal bleeding		Thyroid disorder		Psychiatric disorder	
Stroke		Abnormal blood clotting		Neurological disorder		Depression	
Rapid heart beat		Blood clot/DVT		Seizures		Anxiety	
Varicose veins		Blood transfusion		Breast problems		Dry eyes	
Swollen feet/ankles		Anemia		Breast cancer		Glaucoma	
Lung disease		Autoimmune disease		Cancer		Hearing loss	
Shortness of breath when walking		Diabetes		Skin cancer		Anesthesia problems	
Asthma		Acute infections		Skin disease		Additional	
Chronic cough		Kidney disease		MRSA (Methicillin Resistant Staph Infection)			

Have you ever had a cold sore? Yes_____ No_____
Height:_____ Weight: _____lbs. Weight loss or gain in past year _____lb(s). Loss Gain

Have you ever had a bad reaction to local anesthetic, Novocain, or Epinephrine etc. such as heart racing, feeling jittery, etc?
Yes_____ No _____ Details _____

Previous Surgery/Operations/Hospitalizations (Please list below)

Operation/Hospitalization Year Hospital City Anesthesia (local/general) Surgeon's Name Complications

_____

_____

_____

_____

Allergies: Yes_____ No_____
List any drug related allergies or intolerances, along with reaction to such medicines: _____

_____

Are you sensitive to adhesive tape/suture material? Yes_____ No_____

Medications/Drugs:

List all **medications** you are now taking and their **dosage(s)** including non-prescription drugs, vitamins and herbals, etc.:

_____

_____

_____

Continue…

Has any blood relative had:

	Yes	Afflicted Family Member		Yes	Afflicted Family Member
No contributing family history			Hemophilia		
Adopted			Kidney disease		
Abnormal bleeding			Liver disease		
Von Willebrand			Lung disease		
Abnormal clotting/DVT			Lung cancer		
Anesthesia problems			Breast cancer		
Malignant hyperthermia			Brain tumor		
Autoimmune disorders			Melanoma		
Blood or bleeding disorder			Ovarian cancer		
Blood clotting disorder			Prostate cancer		
Endocrine disease			Skin cancer		
Heart disease			Other cancer		
High blood pressure			Skin disease		
Diabetes			Additional		
Stroke					

Alcohol use: Please check which applies to you
None_____ Socially_____ Daily_____ History of alcoholism_____
How many drinks per week? _____

Smoking Status:
Do you smoke? Yes_____ No_____
How many packs or cigarettes per day?_____
If former smoker, date quit? _____

Illegal Drug Use:
Yes____ No____ Type of illegal drug:_____
How often? _____
Indicate if drugs or alcohol ever posed a dependency problem for you: _____

High Risk Factors: Admits_____ Denies_____

STD History: Admits_____ Denies_____

Social History:
Your Occupation: _____
What is your marital status?_____
How many children do you have?_____
What are the ages of your children?_____
Who do you live with?_____
Support system?_____

Exercise:
Do you exercise?_____
If yes, what type of exercise?_____
How many times per week?_____

Ability to Heal:
Is your skin fragile, sensitive or burns easily? Yes___ No___
Do you form thick or raised scar from a cut or burn? Yes___ No___
Are you a slow or poor healer? Yes___ No___

Women Only:
Do you have regular periods? Yes_____ No_____ N/A_____
Do you take birth control pills or hormone replacement? Yes_____ No_____
Are you going through menopause? Yes_____ No_____
Are you post-menopausal? Yes_____ No_____
Are you pregnant or lactating? Yes____ No____
Breast lump or discharge? Yes____ No ____
During pregnancy, did you ever get hyperpigmentation or masking? Yes____ No____
Date of last Mammogram: _____ Results of mammogram: Normal_____ Abnormal_____
Number of pregnancies: _____ Did you breast feed? Yes_____ No_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____ _____
(Signature of patient or parent if minor) (Date)